State West Virginia

81-5

4.16 Interrelationships with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees

ATTACHMENT 4.16-A

See attachment following this page.

ST. W. Va SA Approved 11/2/81

RO Approved 12/23/81 Effective 10/1/81

NOV 2 1981

81-5

- Arrange for medical supplies, prosthetic or orthotic devices, and equipment needed for treatment or amelioration of the recipient's medical condition.
- Provide or arrange for transportation services to the scheduled clinic or to obtain other services as arranged for the recipient.

2. Records Maintenance

- Provide for the maintenance of records that identify Handicapped Children Services rendered Medicaid children; and, at a minimum, each record will contain the recipient's name, Medicaid identification number, address, birthdate, and all medical reports and/or findings.
- Provide accessibility to all records related to services and expenditures in behalf of Medicaid recipients to DMC and authorized representatives of the Department of Health and Human Services, Health Care Financing Administration.
- Safeguard information regarding Medicaid recipients as required by 42 CFR 431.305.

3. Administration

- Accept medically eligible Medicaid children and youth for services.
- Accept referrals for medically eligible recipients from the Early Periodic Screening, Diagnosis and Treatment (EPSDT) clinics.
- Refer potentially eligible individuals to the appropriate Welfare Area Office to make application for Medicaid assistance.
- Submit claims for clinic services provided on forms and within time frames required by the Medicaid Program.
- Submit annually a budget for clinic operations which will serve as the basis for reimbursement.

ST. W. Va SA Approved 11/2/81

RO Approved 12/23/81 Effective 10/1/81

NOV 4 19

81-5

- Pursue third-party liability in accordance with 42 CFR 433.135.

B. DMC

- Reimburse DHCS for clinic services on an encounter basis to be determined annually using the cost report submitted by DHCS for clinic operations.
- Reimburse providers for covered services arranged by DHCS.
- Assure availability of current eligibility status of Medicaid recipients.

II. MUTUAL RESPONSIBILITIES

A. Exchange case information, medical reports, and statistical reports as needed.

B. Evaluate services, service delivery, new techniques, and other appropriate program coverage issues for program modifications.

C. Exchange information related to provider practice patterns which appear to be outside of accepted norms.

D. Maintain continuous liaison by designation of staff responsible for liaison activities.

III. GENERAL PROVISIONS

A. Activities under this Agreement shall be performed in accordance with the State of West Virginia law and regulations and in accordance with Title XIX of the Social Security Act of 1965 as amended and with Title V of the Social Security Act.

B. All activities under this Agreement will be performed in compliance with the Civil Rights Act of 1964, Title VI.

C. This Agreement may be expanded, modified, or amended at any time by mutual determination of both parties and shall be reviewed and renewed from time to time as needed.

D. All items incorporated by reference are attached as Appendix A.

ST. W.VA SA Approved 11/2/81

O Approved 12/23/81 Effective 10/1/81

NOV 4 1981

81-5

This Agreement becomes operative on the first day of September, 1981.

Approved/Accepted: Helen M. Condry 8/13/81
Director - Division of Medical Care (Date)

Approved/Accepted: Janet Lucas 8/13/81
Administrative Director (Date)
Division of Handicapped Children Services

APPROVED: [signature] 9/10/81
Commissioner - Department of Welfare (Date)
State of West Virginia

ST. W. Va SA Approved 11/2/81

RO Approved 12/23/81 Effective 10/1/81

NOV 4 1981

safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information.

§ 431.301 State plan requirements.

A State plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

§ 431.302 Purposes directly related to State plan administration.

Purposes directly related to plan administration include—

(a) Establishing eligibility;

(b) Determining the amount of medical assistance;

(c) Providing services for recipients; and

(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

§ 431.303 State authority for safeguarding information.

The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about applicants and recipients.

§ 431.304 Publicizing safeguarding requirements.

(a) The agency must publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use.

(b) The agency must provide copies of these provisions to applicants and recipients and to other persons and agencies to whom information is disclosed.

§ 431.305 Types of information to be safeguarded.

(a) The agency must have criteria that govern the types of information about applicants and recipients that are safeguarded.

(b) This information must include at least—

(1) Names and addresses;

(2) Medical services provided;

(3) Social and economic conditions or circumstances;

(4) Agency evaluation of personal information; and

(5) Medical data, including diagnosis and past history of disease or disability.

§ 431.306 Release of information.

(a) The agency must have criteria specifying the conditions for release and use of information about applicants and recipients.

(b) Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the agency.

(c) The agency must not publish names of applicants or recipients.

(d) The agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source. If, because of an emergency situation, times does not permit obtaining consent before release, the agency must notify the family or individual immediately after supplying the information.

(e) The agency's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

(f) If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or recipient, the agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

ST. W-Va SA Approved 11/2/81

Approved 12/23/81 10/1/81

NOV 4 1981

"Premium, subscription charge, or capitation fee" means the fee which is paid by the agency to a contractor for each recipient enrolled under a contract for the provision of medical services under the State plan, whether or not the recipient receives the services during the contract period.

"Prepaid health plan" means an entity that is not an HMO, and that provides medical services under contract with the medicaid agency to enrolled recipients on a prepaid capitation basis. This includes the providers identified in sec. 1903(m)(2)(B) (i), (ii), or (iii) of the act. That section refers to certain entities that received grants under the Public Health Service Act in the fiscal year ending June 30, 1976, certain rural primary health care entities, and certain entities that operated on a prepaid risk basis before 1970.

"Private nonmedical institution" means an entity that—

(1) Provides medical care through contracts or other arrangements with medical providers;

(2) Is paid on a prepaid capitation basis by the agency;

(3) Does not assume an underwriting risk; and

(4) Is not, as a matter of regular business, a prepaid health insuring organization or community health care center. Examples of private nonmedical institutions are child-care institutions and maternity homes.

"Risk" or "underwriting risk" means a significant chance of loss that—

(1) Is assumed by the contractor; and

(2) Arises because the cost of providing services may exceed the premiums, subscription charges, or capitation fees paid by the agency to the contractor during the contract period.

Contract Requirements

§ 431.503 All contracts.

A State plan must provide that contracts under this subpart—

(a) Are in writing;

(b) Specify the contract period;

(c) Specify the functions of the contractor;

(d) Identify the population covered by the contract;

(e) Specify any procedures for enrollment or reenrollment of the covered population;

(f) Specify the amount, duration, and scope of medical services to be provided or paid for;

(g) Provide that the agency and HEW may evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract;

(h) Provide that the agency and HEW may audit and inspect any of the contractor's records that pertain to services performed and determination of amounts payable under the contract;

(i) Specify procedures and criteria for extending the contract;

(j) specify procedures and criteria for renegotiating the contract;

(k) Specify procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding medicaid claims;

(l) Provide that the contractor maintains an appropriate record system for services to enrolled recipients;

(m) Provide that the records referred to in paragraph (l) are retained in accordance with the record retention requirements of 45 CFR Part 74;

(n) Provide that the contractor safeguards information about recipients as required by Subpart F, Part 431 of this subchapter;

(o) Specify any activities to be performed by the contractor that are related to third party liability requirements in § 433.135 of this subchapter;

(p) Specify which functions may be subcontracted; and

(q) Provide that any subcontracts meet the requirements of § 431.504.

[43 FR 45188, Sept. 29, 1978, as amended at 44 FR 17934, Mar. 23, 1979]

§ 431.504 Subcontracts.

(a) Subcontracts must—

(1) Be in writing; and

(2) Fulfill the requirements of this subpart that are appropriate to the service or activity delegated under the subcontract.

(b) No subcontract terminates the legal responsibility of the contractor

ST. Wt. Va SA Approved 11/2/81

HO Approved 12/23/81 Effective 10/1/81

NOV 4 1981

81-5

to the agency to assure that all activities under the contract are carried out.

FISCAL AGENTS, PRIVATE NONMEDICAL INSTITUTIONS, AND HEALTH INSURING ORGANIZATIONS

§ 431.510 Fiscal agents.

If the plan provides for contracts with fiscal agents, it must provide that the contracts—

(a) Meet the requirements of §§ 431.503 and 431.504;

(b) Include termination procedures that require the contractors to supply promptly all material necessary for continued operation of payment and related systems. This material includes—

(1) Computer programs;

(2) Data files;

(3) User and operation manuals, and other documentation;

(4) System and program documentation; and

(5) Training programs for medicaid agency staff, their agents or designated representatives in the operation and maintenance of the system;

(c) Offer to the State one or both of the following options, if the fiscal agent or the fiscal agent's subcontractor has a proprietary right to material specified in paragraph (b) of this section:

(1) Purchase of the material.

(2) Purchasing the use of the material through leasing or other means;

(d) State the amount to be paid to the contractor for performing the functions under the contract;

(e) State the basis for the amount to be paid to the contractor;

(f) State when payment is to be made to the contractor; and

(g) State that payment to providers must be made in accordance with Part 477 of this subchapter.

§ 431.511 Private nonmedical institutions.

If the plan provides for contracts for prepayment of services from private nonmedical institutions, it must provide that the contracts—

(a) Meet the requirements of §§ 431.503 and 431.504;

(b) Specify a capitation fee based on the cost of the services provided, in accordance with the reimbursement requirements prescribed in Part 447 of this subchapter; and

(c) Specify when the capitation amount must be paid.

§ 431.512 Health insuring organization.

(a) If a plan provides for contracts with health insuring organizations, it must provide that the contracts—

(1) Meet the requirements of §§ 431.503 and 431.504;

(2) Specify that the premium or subscription charge must not exceed the limits set forth under Part 447 of this subchapter;

(3) Specify that, except as permitted under paragraph (b) of this section, premiums or subscription charges paid on behalf of each recipient may not be renegotiated—

(i) During the contract period if the contract is for 1 year or less; or

(ii) More often than annually if the contract period is for more than 1 year;

(4) Specify that the premium or subscription charge must not include any amount for recoupment of any losses suffered by the contractor for risks assumed under the same contract or a prior contract with the agency;

(5) Specify that the contractor assumes at least part of the underwriting risk as follows:

(i) If the contractor assumes the full underwriting risk; payment of the premium or subscription charge to the contractor during the contract period constitutes full payment by the agency for the cost of medical services provided under the contract.

(ii) If the contractor assumes less than the full underwriting risk, the contract specifies the apportionment of the underwriting risk.

(6) Specify whether the contractor returns to the agency part of any savings remaining after allowable costs are deducted from the premium or subscription charge and, if savings are returned, the apportionment to the agency and the contractor;

(7) Specify the extent, if any, to which the contractor may obtain reinsurance of a portion of the underwriting risk;

(8) Specify the actuarial basis for computation of the premium or subscription charge.

ST. W. Va SA Approved 11/2/81

HO Approved 12/23/81 Effective 10/1/81

NOV 4 1981

81-5

plan, or to each person in a sample group of people who received services. This notice must specify—

(i) The service furnished;

(ii) The name of the provider furnishing the service;

(iii) The date on which the service was furnished; and

(iv) The amount of the payment made under the plan for the service.

(3) The written notice must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(4) The system provides both patient and provider profiles for program management and utilization review purposes.

§ 433.114 Termination of FFP for failure to provide access to claims processing and information retrieval systems.

The Administrator will terminate FFP at any time if the medicaid agency fails to provide State and Federal representatives with full access to the system, including on-site inspection. The Administrator may request such access at any time to determine whether the conditions in this subpart are being met.

Subpart D—Third Party Liability

§ 433.135 Third party liability: determination of liability and collection procedures.

(a) *Basis and purpose.* This subpart implements sec. 1902(a)(25) and 1903(d)(2) of the Act by setting forth State plan requirements concerning—

(1) The legal liability of third parties to pay for services provided under the plan; and

(2) Treatment of reimbursements by a third party to a State for medicaid furnished under the plan.

(b) *Definitions.* For purposes of this subpart, "third party" means any entity that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient of medicaid.

(c) *Requirements for State plans.* A State plan must provide that requirements of paragraphs (d)-(g) of this section are met.

(d) *Determining liability of third parties.* The medicaid agency must take reasonable measures to determine the legal liability of third parties to pay for services under the plan.

(e) *Payment of claims.* (1) If the agency has determined that—

(i) Third party liability exists for part or all of the services provided to a recipient; and

(ii) The third party will make payment within a reasonable time, the agency must pay only the amount, if any, by which the allowable claim exceeds the amount of the liability.

(2) The agency may not withhold payment for services provided to a recipient if third party liability or the amount of liability cannot be determined, or payments will not be available, within a reasonable time.

(f) *Reimbursement for medicaid.* The agency must seek reimbursement for medicaid to the extent of a third party's legal liability if—

(1) Liability is determined after medicaid is provided to an individual; or

(2) Liability was determined before providing medicaid but the agency failed to make use of it.

(g) *Repayment of Federal share.* If the State has received FFP in medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP for the State.

(h) *Federal financial participation.* FFP is not available in medicaid payments, to the extent of the Federal proportion of the third party liability, if—

(1) Third party liability existed when medicaid payments were made, but was disregarded at that time and not subsequently recovered;

(2) The agency failed to take reasonable steps to collect reimbursement from a third party; or

(3) The agency received reimbursement from a liable third party.

ST. W. Va SA Approved 11/2/81

RO Approved 12/23/81 Effective 10/1/81

NOV 4 1981

71-3

AGREEMENT FOR COOPERATIVE SERVICES
BETWEEN
THE DEPARTMENT OF HEALTH
AND THE DEPARTMENT OF WELFARE

This agreement sets forth the objectives of the cooperative program between the Social Security Act, Title V, grantee programs as administered by the West Virginia Department of Health and the Title XIX Program as administered by the West Virginia Department of Welfare. It includes the responsibilities of both agencies for direction and coordination, services, staffing, financing, operating procedures, exchange of information and confidentiality. The purpose is to provide a base for cooperation and the blending of resources of the two agencies.

I. Mutual Objectives and Respective Responsibilities

A. Mutual Objectives

The objectives of this cooperative program are to develop and improve professional techniques and administrative methods which will increase the number of eligible recipients who can receive a wider range of medical and remedial services and to improve the quality of services available.

1. Develop systematic methods for the identification of persons in need of medical and social services.
2. Develop and maintain an effective system of coordination of agency services in order to insure optimum utilization of available services.
3. Emphasize early and appropriate referral and promptness of services.
4. Develop a cooperative program of medical and social evaluation.
5. Compile and analyze data on patients referred, the costs and results, and the usefulness of the methods used.

St. W. Va. Tr. 3/2/74 Incorp. 11/12/74 Effective 12/28/73

MAR 12 1974

B. Respective Responsibilities

1. Department of Health: To offer consultation and programs (including early identification) concerned with the health of mothers and children; to cooperatively plan and carry out local health programs for mothers and children, as funds are available; to provide financial support for local maternal and child health programs which include: maternity clinics, family planning and child spacing clinics, child health conferences, immunization clinics, pediatric clinics, and mental retardation diagnostic clinics. To develop and promote public dental health programs encompassing education, treatment and prevention. (These services represent "Title V Grantee" programs as administered by the West Virginia Department of Health; i.e., MCH, M & I projects, MR, and projects for dental health of children. The Crippled Children's Services Program is administered by the West Virginia Department of Welfare).

2. Department of Welfare: The Department of Welfare administers the Title XIX Program in West Virginia which includes the following responsibilities to persons determined eligible for medical assistance to promote general health, to correct or limit disability, to treat all illnesses, to provide rehabilitation to persons with impairments, and to make essential health and medical services of high quality available to all eligible individuals at a realistic level of reimbursement at the place and time needed.

II. Arrangements for Early Identification of Individuals Under 21 Years of Age in Need of Medical or Remedial Care and Services

The Department of Welfare will use the following regularly scheduled screening and diagnostic clinics of the Department of Health for the purpose